Eur J Vasc Endovasc Surg **22**, 477–479 (2001)

Correspondence

Bilateral Carotid Endarterectomy

Sir,

I found it interesting to read the impressive results of the bilateral one-stage carotid endarterectomy by Kumar *et al.*[1] and would like to take this opportunity to endorse their surgical approach following our own experience on the matter. Reports of simultaneous bilateral carotid endarterectomy (SBCE) in cases of significant bilateral occlusive disease is rare in the literature in the last 30 years.[2,3] This is mainly caused by the fear of a higher incidence of neurological complication,[4] myocardial infarction or hyperperfusion syndrome. In particular, the risk of damage to the cranial nerves during SBCE exists, carrying distressing consequences in the case of bilateral lesions. However, as our experience has shown in the last decade[5] the risk of such complications as a result of iatrogenic trauma is avoidable with a good surgical technique. Rigorous selection of patients is also a prerequisite for a one-stage bilateral carotid reconstruction. We reported the indications for SBCE, together with our results, which were comparable with those patients who had undergone staged bilateral carotid endarterectomy.[5] The authors add one more indication for SBCE, i.e. patients with crescendo transient ischaemic attacks, and we agree with this.

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doi:10.1053/ejvs.2001.1498,
available online at http://www.idealibrary.com on IDEAL®

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Bilateral Carotid Endarterectomy

Author's Reply

Thank you for offering us the opportunity to reply to the letter from Dimakakos.

Most of the papers Dimakakos quoted include patients who have undergone bilateral one stage carotid endarterectomy for asymptomatic disease. The message from our paper is that bilateral one stage carotid endarterectomy is only indicated in patients with bilateral symptomatic disease.

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Patient Scoring Systems

Sir,

The article by Shuhaiber *et al.*[1] highlights the importance of good surgical audit in a non-specialist vascular unit using a widely accepted scoring system for assessing post-operative morbidity and mortality.[2]

This is a timely report and illustrates the truly excellent results that can be achieved in aortic aneurysm repair in a non-specialist single-handed vascular unit with small numbers per year. Recent trends in vascular surgery have gone towards regionalisation and centralisation of resources to vascular units serving a catchment area of at least 500 000 inhabitants. This rationale certainly has its merits but can place unacceptable hardship on patients having to travel long distances away from family supports etc.